

SAMPLE RESOLUTION
Wisconsin Department of Employee Trust Funds

A RESOLUTION FOR INCLUSION UNDER THE
WISCONSIN PUBLIC EMPLOYERS'
GROUP HEALTH INSURANCE PROGRAM

RESOLVED, by the School Board of the Southern Community School District of WI
(Governing Body) (Employer Legal Name)

that pursuant to the provisions of Section 40.51 (7) of the Wisconsin Statutes hereby determines to offer the Group Health Insurance Program to eligible personnel through the program of the State of Wisconsin Group Insurance Board, and agrees to abide by the terms of the program as set forth in the contract between the Group Insurance Board and the participating health insurance providers.

All participants in the WPE Group Health Insurance Program will need to be enrolled in either the Traditional HMO Option or the Deductible HMO Option. An employer may not split its group between the two options.

We choose to participate in the: (check only one box)

- ☐ Traditional HMO Option paired with the Classic Standard Plan
- ☐ Traditional HMO Option paired with the Standard PPP
- ☐ Deductible HMO Option paired with the Deductible Standard Plan
- ☒ Deductible HMO Option paired with the Deductible Standard PPP

The resolution shall be effective on the later of the 1st of the month on or after 90 days following its receipt in the Department of Employee Trust Funds, or

February 1, 2005
(specify a later effective date, 1st of month only)

The proper officers are herewith authorized and directed to take all actions and make salary deductions for premiums and submit payments required by the State of Wisconsin Group Insurance Board to provide such Group Health Insurance.

CERTIFICATION

I hereby certify that the foregoing resolution is a true, correct and complete copy of the resolution duly and regularly passed by the above governing body on the 15th day of October, 2001 and that said resolution has not been repealed or amended, and is now in full force and effect.

Dated this 18th day of October, 2004.

I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent statements, and hereby certify that, to the best of my knowledge and belief, the above information is true and correct.



Employer Representative Clerk
Title

Dodge County
Employer County

P. O. Box 5
Southern, WI 53710
Mailing Address

Number of eligible employees 10

7089-000
ETF Employer Identification Number

Wisconsin Department of Employee Trust Funds

A RESOLUTION FOR INCLUSION UNDER THE WISCONSIN PUBLIC EMPLOYERS'
GROUP HEALTH INSURANCE PROGRAM

RESOLVED, by the _____ of the _____
(Governing Body) (Employer Legal Name)

that pursuant to the provisions of Section 40.51 (7) of the Wisconsin Statutes hereby determines to offer the Group Health Insurance Program to eligible personnel through the program of the State of Wisconsin Group Insurance Board, and agrees to abide by the terms of the program as set forth in the contract between the Group Insurance Board and the participating health insurance providers.

All participants in the WPE Group Health Insurance Program will need to be enrolled in either the Traditional HMO Option or the Deductible HMO Option. An employer may not split its group between the two options.

We choose to participate in the: (check only one box)

- ☐ Traditional HMO Option paired with the Classic Standard Plan
- ☐ Traditional HMO Option paired with the Standard PPP
- ☐ Deductible HMO Option paired with the Deductible Standard Plan
- ☐ Deductible HMO Option paired with the Deductible Standard PPP

The resolution shall be effective on the later of the 1st of the month on or after 90 days following its receipt in the Department of Employee Trust Funds, or

(specify a later effective date, 1st of month only)

The proper officers are herewith authorized and directed to take all actions and make salary deductions for premiums and submit payments required by the State of Wisconsin Group Insurance Board to provide such Group Health Insurance.

CERTIFICATION

I hereby certify that the foregoing resolution is a true, correct and complete copy of the resolution duly and regularly passed by the above governing body on the ____ day of _____, year ____ and that said resolution has not been repealed or amended, and is now in full force and effect.

Dated this ____ day of _____, year ____.

I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent statements, and hereby certify that, to the best of my knowledge and belief, the above information is true and correct.

Employer Representative Title

Employer County

Mailing Address

Number of eligible employees ____

ETF Employer Identification Number

Wisconsin Department of Employee Trust Funds

A RESOLUTION FOR INCLUSION UNDER THE WISCONSIN PUBLIC EMPLOYERS'
GROUP HEALTH INSURANCE PROGRAM WITH A REQUEST FOR A TEMPORARY WAIVER
OF THE MINIMUM PARTICIPATION REQUIREMENT

RESOLVED, by the _____ of the _____
(Governing Body) (Employer Legal Name)

that pursuant to the provisions of Section 40.51 (7) of the Wisconsin Statutes hereby determines to offer the Group Health Insurance Program to eligible personnel through the program of the State of Wisconsin Group Insurance Board, and agrees to abide by the terms of the program as set forth in the contract between the Group Insurance Board and the participating health insurance providers.

All participants in the WPE Group Health Insurance Program will need to be enrolled in either the Traditional HMO Option or the Deductible HMO Option. An employer may not split its group between the two options.

We choose to participate in the: (check only one box)

- ☐ Traditional HMO Option paired with the Classic Standard Plan
☐ Traditional HMO Option paired with the Standard PPP
☐ Deductible HMO Option paired with the Deductible Standard Plan
☐ Deductible HMO Option paired with the Deductible Standard PPP

Be it further resolved that the _____
(Governing body)

requests a temporary waiver of the requirement to meet the minimum participation rate because of the timing of collective bargaining agreements. It is understood that when these agreements are finalized, the minimum participation requirement will be met.

The resolution shall be effective on the later of the 1st of the month on or after 90 days following its receipt in the Department of Employee Trust Funds, or

_____.
(specify a later effective date, 1st of month only)

The proper officers are herewith authorized and directed to take all actions and make salary deductions for premiums and submit payments required by the State of Wisconsin Group Insurance Board to provide such Group Health Insurance.

CERTIFICATION

I hereby certify that the foregoing resolution is a true, correct and complete copy of the resolution duly and regularly passed by the above governing body on the _____ day of _____, year _____ and that said resolution has not been repealed or amended, and is now in full force and effect.

Dated this _____ day of _____, year _____.

I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent statements, and hereby certify that, to the best of my knowledge and belief, the above information is true and correct.

Employer Representative Title

Employer County

Mailing Address

Number of eligible employees ____

ETF Employer Identification Number

Wisconsin Department of Employee Trust Funds

A RESOLUTION FOR INCLUSION UNDER THE WISCONSIN PUBLIC EMPLOYERS'
GROUP HEALTH INSURANCE PROGRAM WITH A REQUEST TO RETAIN A SECOND GROUP
HEALTH PLAN

RESOLVED, by the _____ of the _____
(Governing Body) (Employer Legal Name)

that pursuant to the provisions of Section 40.51 (7) of the Wisconsin Statutes hereby determines to offer the Group Health Insurance Program to eligible personnel through the program of the State of Wisconsin Group Insurance Board, and agrees to abide by the terms of the program as set forth in the contract between the Group Insurance Board and the participating health insurance providers.

All participants in the WPE Group Health Insurance Program will need to be enrolled in either the Traditional HMO Option or the Deductible HMO Option. An employer may not split its group between the two options.

We choose to participate in the: (check only one box)

- ☐ Traditional HMO Option paired with the Classic Standard Plan
☐ Traditional HMO Option paired with the Standard PPP
☐ Deductible HMO Option paired with the Deductible Standard Plan
☐ Deductible HMO Option paired with the Deductible Standard PPP

Be it further resolved that the _____
(Governing Body)

requests to retain a second group health plan, separate from the Wisconsin Public Employers' group, under the provisions outlined as follows:

1. Overall Participation. If a portion of the non-participating employees are covered by some other plan, it must be demonstrated to the satisfaction of the Board that excluding such sub-group will not result in adverse selection. Regardless, the minimum participation level must be met, which is based on the number of all eligible employees of this employer that participate in this local group health insurance program.
2. Standard Plan vs. HMOs. If less than 50% of the participating employees elect the Standard Plan coverage, after the first year in this program the Plan Stabilization Contribution (PSC) may be increased by up to \$2 for each year that the average age of the employer group exceeds the average age of all other Standard Plan participants in the Wisconsin Public Employers' Group Health Insurance Program. The maximum increase in the PSC would be \$10.
3. Contract. Such a new employer must agree to participate in this local group health insurance program for a minimum period of three years.

The resolution shall be effective on the later of the 1st of the month on or after 90 days following its receipt in the Department of Employee Trust Funds, or

(specify a later effective date, 1st of month only)

The proper officers are herewith authorized and directed to take all actions and make salary deductions for premiums and submit payments required by the State of Wisconsin Group Insurance Board to provide such Group Health Insurance.

CERTIFICATION

I hereby certify that the foregoing resolution is a true, correct and complete copy of the resolution duly and regularly passed by the above governing body on the ____ day of _____, year ____ and that said resolution has not been repealed or amended, and is now in full force and effect.

Dated this ____ day of _____, year _____.

Employer Representative Title

Employer County

Mailing Address

Number of eligible employees

ETF Employer Identification Number

**WISCONSIN PUBLIC EMPLOYERS
LARGE GROUP UNDERWRITING CHECKLIST/QUESTIONNAIRE**

All Information must be sent to Self-Insured Health Plan Manager at ETF
PO Box 7931, Madison, WI 53707-7931
801 W. Badger Rd., Madison, WI 53702
Fax (608) 267-0633

- ☐ Check made out to Blue Cross & Blue Shield of Wisconsin (BCBSWI) for cost of Underwriting for \$1,200.
- ☐ Check made out to Deloitte LLP for cost of Underwriting for \$1,200.
- ☐ Employer Questionnaire checklist from ET-1139 (this form).
- ☐ WRS Group Name: _____.
- ☐ Employer Identification Number (EIN) _____.
- ☐ Group Contact (name) _____.
- ☐ Group Contact phone/fax _____.
- ☐ Group Physical Address: _____.

_____.
- ☐ County Location of Employer: _____.
- ☐ Effective Date of Quote (Offered no sooner than 120 days from the renewal/effective date of the client: _____).
- ☐ Number of *all* employees on payroll including part time and seasonal *and all retirees* whether or not they meet WRS eligibility requirements: _____.
- ☐ Number of WRS eligible employees including part time and seasonal *and retirees*: _____.
- ☐ Attach census data for all eligible employees and retirees noting those employees who are in their probationary period, receiving Cobra benefits and Cobra end date, or waiving coverage under the current benefit plan. Census data should include:
 - o The employee by name, employee number, or numeric assigned number
 - o Date of birth or age
 - o Sex
 - o Current status of their insurance EE (single), EC (employee/child{ren}), ES (employee/spouse), F (family) preferable. At a minimum EE & F
 - o Zip code of the employee's address
- ☐ US Dept. of Labor- Standard Industrial Classification (SIC) code (for example: 9199: General Government, Not Elsewhere Classified): #_____.
- ☐ What is your anticipated employer contribution?: _____.
- ☐ What is your anticipated probationary period for health insurance eligibility? (For example, 1st of the month following 60 days): _____.
- ☐ Current insurance carrier and years enrolled with current carrier: _____
_____/_____.
- ☐ **For current self-funded groups and insured groups with experience data attach:**
 - o Twenty-four months (12 months minimum) of claims data
 - o Enrollment data (month by month summary of enrollment by single, limited family, family)
 - o Benefit plans in force for each year of rate history
 - o Employer contribution
 - o **High cost claims data (over \$25,000) detail including dollar amount, diagnosis, current status (enrolled or cancelled) and prognosis (if available) This information cannot include name, Social Security number, or any information that would identify the individual.**

OVER

- **For insured groups with carriers who do not provide experience data:**
 - 3 years of rate history, including renewal rates
 - Enrollment (summary of enrollment by single, limited family, and family) for each of 3 year rate history
 - Benefit plans in force for each year of rate history
 - High cost claim (over \$25,000) detail including dollar amount, diagnosis, current status (enrolled or cancelled) and prognosis (if available) *This information cannot include name, social security number, or any information that would identify the individual.*